Saginaw Bay Dermatology

Brent M. Boyce M.D.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____ Social Security #_____

1. I Authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure

Brent M. Boyce, M.D.
Saginaw Bay Dermatology
106 E. Main St.
Sebewaing, Mi 48759
Fax: 989-883-9131

3. The type and amount of information to be used or disclosed is as follows:

☐ Operative Reports
☐ List of Allergies
☐ Laboratory / Biopsy Results
☐ Consultation Reports
☐ Other_____
☐ Medication List
☐ Most Recent Office Notes
☐ X-Ray and Imaging Reports
☐ Entire Record

DATE OF SERVICE REQUESTED:_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Privacy Officer at (989) 894-8400.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Signature of Witness